NATIONAL QUALITY FORUM

Welcome to Today's Meeting!

- Housekeeping reminders:
  - Please **mute** yourself when **not** speaking
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at **MAPRural@qualityforum.org**

NATIONAL QUALITY FORUM
Driving measurable health improvements together

https://www.qualityforum.org

Measure Applications Partnership (MAP)

Rural Health Advisory Group Review Web Meeting

December 8, 2021

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003 Option Year 3.

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Agenda

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- CMS Opening Remarks
- Overview of Pre-Rulemaking Approach
- Discuss Measures Under Consideration (MUC) List
  - Clinician Programs
  - Hospital Programs
  - Post-Acute Care/Long-Term Care (PAC/LTC) Programs
  - Measures Proposed for Multiple Programs
- Discussion of Rural Health Emergency Hospital Program
- Opportunity for Public Comment
- Next Steps and Closing Comments
- Adjourn

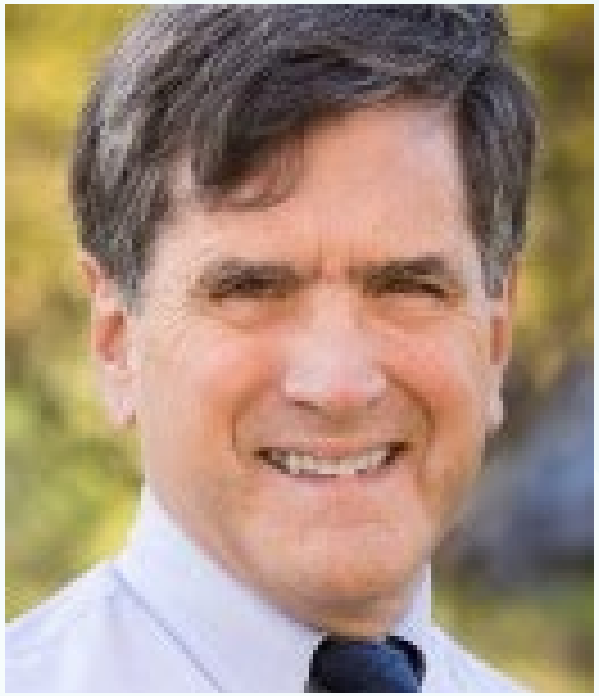
Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Welcoming Remarks from NQF Leadership

Dana Gelb Safran, Sc.D.
President & CEO
National Quality Forum

Welcoming Remarks from Advisory Group Co-Chairs

Kimberly Rask, MD, PhD
Alliant Health Solutions



Keith Mueller, PhD
RUPRI Center for Rural Health Policy Analysis

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Disclosures of Interest

- State your name, title, organization, brief bio, and acknowledge the disclosure(s) you listed in your DOI form if applicable
- Briefly note any of the following disclosures relevant to the project:
  - Engagement with project sponsors *(Centers for Medicare & Medicaid Services)*
  - Research funding, consulting/speaking fees, honoraria
  - Ownership interest
  - Relationships, activities, affiliations, or roles

Example: I'm Joan Smith, Chief Medical Officer of ABC Healthcare. I am also a Principal Investigator for a research project examining rural-specific health issues funded by XYZ Organization.

Rural Health Advisory Group Membership

Advisory Group Co-Chairs: Kimberly Rask, MD, PhD / Keith Mueller, PhD

Organizational Members (Voting)

- American Academy of Family Physicians
- American Academy of Physician Assistants
- American College of Emergency Physicians
- American Hospital Association
- American Society of Health-System Pharmacists
- Lifepoint Health
- Michigan Center for Rural Health
- Minnesota Community Measurement
- National Association of Rural Health Clinics
- National Rural Health Association
- National Rural Letter Carriers' Association
- Truven Health Analytics LLC/IBM Watson Health Company
- UnitedHealth Group

Rural Health Advisory Group Membership (cont.)

Individual Subject Matter Experts (Voting)

- Michael Fadden, MD
- Rev. Bruce Hanson
- Karen James, PhD, MS
- Cody Mullen, PhD
- Jessica Schumacher, PhD, MS
- Ana Verzone, MS, APRN, DNP, CNM
- Holly Wolff, MHA

Federal Government Liaisons (Nonvoting)

- Centers for Medicare & Medicaid Services (CMS)
- Health Resources & Services Administration (HRSA)
- Indian Health Service (IHS)

MAP Rural Health Advisory Group Staff

Chelsea Lynch, MPH, MSN, RN, CIC
Director

Katie Berryman, MPAP, PMP,
Senior Project Manager

Susanne Young, MPH,
Manager

Amy Guo, MS,
Manager

Victoria Freire, MPH, CHES®,
Analyst

Gus Zimmerman, MPP,
Coordinator

CMS Staff

- **Kimberly Rawlings,** Task Order Contracting Officer's Representative (TO COR)
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity Contracting Officer's Representative (IDIQ COR)

CMS Welcoming Remarks

Measure Applications Partnership

Rural Health Advisory Group

December 2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Purpose of the MAP

- The Measure Applications Partnership is a convened group of experts who provide recommendations to CMS about whether or not measures under consideration should be included in CMS value-based programs.
- Multi-stakeholder group feedback on the MUC List is a statutory requirement.
- MAP makes recommendations but does not have final authority for decisions around CMS programs.
- However, all MAP recommendations are strongly considered and assist CMS in decisions about programs.
- Measure set review was new for MAP this year.

Rural MAP

- The Rural MAP considers all measures across all programs to ensure that measures are assessed through the lens of the special needs of rural health. Important issues include:
  - Small numbers for reporting
  - Access to care
  - Potential unintended consequence of measures specific to rural health

CMS Key Focus Areas for Quality

- COVID-19 and the PHE
- Equity – Access, Outcomes, Referrals, Experience
- Maternal Health and Safety
- Mental Health
- Resiliency and Emergency Preparedness
- Safety – not just patient safety, but workforce safety
- Digital transformation
- Climate Change
- Value

Upcoming Initiatives in Rural Health

- Digital Healthcare – digital transformation, telehealth, access to broadband
- Rural ED
- Automatic EUC Policy for 2021 MIPS
- MIPS transformation to MIPS Value Pathways

Summary

- Thank you for your contributions and your important voice for rural healthcare
- Thank you for you contributions and heroic efforts for the COVID-19 PHE
- Look forward to your comments and recommendations today on the measures moving forward
- Happy Holidays!

MAP Rural Health Advisory Group 2021 Pre-Rulemaking Activities

MAP Rural Health Advisory Group Charge

- Provide timely input on rural-specific measurement issues to other MAP workgroups and committees
- Provide rural perspectives on the selection of quality measures in MAP
- Provide input to address priority rural health issues, including the challenge of low case-volume

Rural Health Advisory Group Review of Measures Under Consideration

- The Rural Health Advisory Group will review the measures under consideration (MUC) list and provide the following feedback to the setting-specific Workgroups:
  - Relative priority/utility in terms of access, cost, or quality issues encountered by rural residents
  - Data collection and/or reporting challenges for rural providers
  - Methodological problems of calculating performance measures for small rural facilities
  - Potential unintended consequences of inclusion in specific programs
  - Gap areas in measurement relevant to rural residents/providers for specific programs

Rural Health Advisory Group Feedback on Measures Under Consideration

Rural Health Advisory Group feedback will be provided to the setting-specific Workgroups through the following mechanisms:

- Preliminary analyses (PAs):
  - A qualitative summary of Rural Health Advisory Group's discussion of the MUCs
  - Polling results that quantify the Rural Health Advisory Group's perception of suitability of the measures under consideration for various programs
    - Average polling results
- Rural Health Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December

Process for Today's Discussion

- **Step 1.** NQF staff describes the program in which the measure is being proposed
- **Step 2.** The lead discussant will summarize the measure and offer initial thoughts about inclusion of the measure into the program
- **Step 3.** Advisory Group discusses each measure and provides feedback on:
  - Relative priority/utility in terms of access, cost, or quality issues encountered by rural residents
  - Data collection and/or reporting challenges for rural providers
  - Methodological problems of calculating performance measures for small rural facilities
  - Potential unintended consequences related to rural health if the measure is included in specific programs

Process for Today's Discussion (cont.)

- **Step 4.** Advisory Group takes a poll on whether the measure is suitable for use with rural providers within the specific program of interest
  - Range is 1-5, from least suitable to most for the program
- **Step 5.** Advisory Group discusses gap areas in measurement relevant to rural residents/providers for the specific program

Measures Under Consideration 2021-2022

Measures Proposed for Clinician Programs

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MAP Clinician Workgroup Programs Under Discussion

Merit-based Incentive Payment System (MIPS)

Medicare Part C & D Star Ratings

Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
  - Pay-for-performance
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
  - The MIPS performance categories and finalized 2021 weights:
    - Quality (40%)
    - Promoting Interoperability (25%)
    - Improvement Activities (15%)
    - Cost (20%)
    - The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
  - Improve quality of patient care and outcomes for Medicare FFS.
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.

MUC2021-125: Psoriasis – Improvement in Patient-Reported Itch Severity

Description: The percentage of patients, aged 18 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Level of Analysis: Clinician

Risk Adjustment: None

Lead Discussants:

- Brock Slabach, National Rural Health Association
- Jorge Duchiela, American Academy of Family Physicians (AAFP)

MUC2021-135: Dermatitis – Improvement in Patient-Reported Itch Severity

Description: The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Level of Analysis: Clinician

Risk Adjustment: None

Lead Discussants:

- Brock Slabach, National Rural Health Association
- Jorge Duchiela, American Academy of Family Physicians (AAFP)

MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)

Description: The percentage of adult patients 18 years and older who had an elective primary total hip arthroplasty (THA) or total knee arthroplasty (TKA) during the performance period AND who completed both a pre- and post-surgical care goal achievement survey and demonstrated that 75% or more of the patient's expectations from surgery were met or exceeded.

The pre- and post-surgical surveys assess the patient's main goals and expectations (i.e., pain, physical function and quality of life) before surgery and the degree to which the expectations were met or exceeded after surgery. The measure will be reported as two risk-adjusted rates stratified by THA and TKA.

Level of Analysis: Clinician; Group

Risk Adjustment: Risk Adjusted; Stratified

Lead Discussants:

- Rhonda Robinson Beale, UnitedHealth Group
- Karen James, Subject Matter Expert

MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Description: The measure will estimate a clinician- and clinician group-level, risk-standardized improvement rate for patient-reported outcomes (PROs) following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age or older. Substantial clinical benefit (SCB) improvement will be measured by the change in score on the joint-specific patient-reported outcome measure (PROM) instruments, measuring hip or knee pain and functioning, from the preoperative assessment (data collected 90 to 0 days before surgery) to the postoperative assessment (data collected 300 to 425 days following surgery).

Level of Analysis: Clinician; Group

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Collette Cole, Minnesota Community Measurement
- Collette Cole, Minnesota Community Measurement

MUC2021-090: Kidney Health Evaluation

Description: Percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the 12-month measurement period

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Michael Fadden, Subject Matter Expert
- Cody Mullen, Subject Matter Expert

MUC2021-127: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

Description: Percentage of patients aged 18 years and older with a diagnosis of CKD (Stages 1-5, not receiving Renal Replacement Therapy (RRT) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period.

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Rena Sackett, American Society of Health-System Pharmacists
- Stacy Scroggins, American Academy of Physician Assistants (AAPA)

MUC2021-105: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

Description: Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Jessica Schumacher, Subject Matter Expert
- Jorge Duchiela, American Academy of Family Physicians (AAFP)

MUC2021-058: Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors

Description: Percentage of patients, aged 18 years and older, with a diagnosis of cancer, on immune checkpoint inhibitor therapy, and grade 2 or above diarrhea and/or grade 2 or above colitis, who have immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered.

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Sandi Hyde, LifePoint Health
- Stacy Scroggins, American Academy of Physician Assistants (AAPA)

Lunch

Part C and D Star Ratings

- **Program Type:** Quality Payment Program and Public Reporting
- **Incentive Structure:**
  - Medicare Advantage: Public reporting and quality bonus payments (QBP)
  - Stand-alone Prescription Drug Plans: Public reporting
- **Program Goal:**
  - Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices
  - Incentivize high performing plans (Part C)

The April 2018 final rule (CMS-4282-F) initially codified the methodology for the Part C and Part D Star Ratings

MUC2021-053: Concurrent Use of Opioids and Benzodiazepines (COB)

Description: The percentage of Medicare Part D beneficiaries, 18 years or older with concurrent use of prescription opioids and benzodiazepines during the measurement period.

Level of Analysis: Health Plan

Risk Adjustment: None

Lead Discussants:

- Cody Mullen, Subject Matter Expert
- Rena Sackett, American Society of Health-System Pharmacists

MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

Description: The percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period.

Level of Analysis: Health Plan

Risk Adjustment: None

Lead Discussants:

- Rena Sackett, American Society of Health-System Pharmacists
- Jessica Schumacher, Subject Matter Expert

MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)

Description: The percentage of Medicare Part D beneficiaries 65 years of age or older, with concurrent use of 3 or more unique central-nervous system (CNS)-active medications during the measurement period.

Level of Analysis: Health Plan

Risk Adjustment: None

Lead Discussants:

- Karen James, Subject Matter Expert
- Rhonda Robinson Beale, UnitedHealth Group

Measures Proposed for Hospital Programs

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MAP Hospital Workgroup Programs Under Discussion

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.
- **Program Goal:** Improve the quality of dialysis care and produce better outcomes for beneficiaries.

MUC2021-101: Standardized Readmission Ratio (SRR) for Dialysis Facilities

Description: The Standardized Readmission Ratio (SRR) for a dialysis facility is the ratio of the number of observed index discharges from acute care hospitals to that facility that resulted in an unplanned readmission to an acute care hospital within 4-30 days of discharge to the expected number of readmissions given the discharging hospitals and the characteristics of the patients and based on a national norm. Note that the measure is based on Medicare-covered dialysis patients.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Sandi Hyde, LifePoint Health
- Bill Finerfrock, National Association of Rural Health Clinics

Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-106: Hospital Commitment to Health Equity

Description: Among Medicare beneficiaries, racial and ethnic minority individuals, individuals with limited English proficiency or disabilities often receive lower quality of care and higher rates of readmission and complications than beneficiaries without these characteristics. Strong and consistent hospital leadership can be instrumental in setting specific, measurable, and attainable goals to advance equity priorities and improve care for all beneficiaries. This includes promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes, which are assessed in this measure.

Level of Analysis: Facility

Risk Adjustment: None

Lead Discussants:

- Bill Finerfrock, National Association of Rural Health Clinics
- Crystal Barter, Michigan Center for Rural Health

MUC2021-122: Excess Days in Acute Care (EDAC) After Hospitalization For Acute Myocardial Infarction (AMI)

Description: This measure estimates days spent in acute care within 30 days of discharge from an inpatient hospitalization for AMI. This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm (PRA). Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of half-day increments.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Anisha Turner, American College of Emergency Physicians
- Stephen Tahta, American Hospital Association

MUC2021-120: Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty (THA/TKA)

Description: This measure estimates hospital-level, risk-standardized payments for an elective primary total THA/TKA episode of care, starting with an inpatient admission to a short-term acute care facility and extending 90 days post admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Crystal Barter, Michigan Center for Rural Health
- Perry Payne, Truven Health Analytics LLC/IBM Watson Health

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- **Program Type:** Quality Reporting Program
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

MUC2021-091: Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer

Description: Percentage of female patients aged 18 to 70 with stage I (T1c) – III HER-2 positive breast cancer for whom appropriate treatment is initiated

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Jorge Duchiela, American Academy of Family Physicians (AAFP)
- Ana Verzone, Subject Matter Expert

Break

Measures Proposed for PAC/LTC Programs

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MAP PAC/LTC Workgroup Programs Under Discussion

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Skilled nursing facilities (SNFs) that do not submit the required quality data will have their annual payment update reduced by 2%.
- **Program Goals:** Increase transparency so that patients are able to make informed choices.

MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel

Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

Level of Analysis: Facility

Risk Adjustment: None

Lead Discussants:

- Cameron Deml, National Rural Letter Carriers' Association (NRLCA)
- Bill Finerfrock, National Association of Rural Health Clinics

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Program Type:** Value-Based Purchasing
- **Incentive Structure:** The SNF VBP Program awards incentive payments to SNFs based on a single all-cause readmission measure (SNF 30-Day All-Cause Readmission Measure; NQF #2510), as mandated by Protecting Access to Medicare Act (PAMA) of 2014. SNFs' performance period risk-standardized readmission rates are compared to their own past performance to calculate an improvement score and the National SNF performance during the baseline period to calculate an achievement score. The higher of the achievement and improvement scores becomes the SNF's performance score.
- SNFs with less than 25 eligible stays during the baseline period will not receive an improvement score. These SNFs will be scored on achievement only. SNFs with less than 25 eligible stays during the performance period will be "held harmless".
- **Program Goal:** Transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely volume, and linking payments to performance on a single readmission measure.

Protecting Access to Medicare Act (PAMA) and The Consolidated Appropriations Act of 2021

- The Protecting Access to Medicare Act (PAMA) of 2014 authorized the SNF VBP Program.
- Per PAMA, the all-cause measure will be replaced as soon as practicable with a potentially preventable readmission measure.
- CMS withholds 2% of SNF Medicare FFS payments to fund the Program, and 60% of these withheld funds are redistributed to SNFs in the form of incentive payments.
- The SNF VBP Program began awarding incentive payments to SNFs on October 1, 2018.
- The Consolidated Appropriations Act of 2021 allows the Secretary to apply up to 9 additional measures, which may include measures focusing on functional status, patient safety, care coordination, or patient experience for payments for services furnished on or after October 1, 2023.

MUC2021-095: CoreQ: Short Stay Discharge Measure

Description: The measure calculates the percentage of individuals discharged in a six month time period from a SNF, within 100 days of admission, who are satisfied (scoring a 3 or above on the survey).

Level of Analysis: Facility; Other: Resident

Risk Adjustment: None

Lead Discussants:

- Rev. Bruce Hanson, Subject Matter Expert
- Michael Fadden, Subject Matter Expert

MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)

Description: This measure estimates the risk-adjusted rate of successful discharge to community from a SNF, with successful discharge to community including no unplanned rehospitalizations and no death in the 31 days following SNF discharge. The measure is calculated using the following formula: (risk-adjusted numerator/risk-adjusted denominator)*national observed rate. The fields below describe the adjusted numerator and denominator in more detail. The measure is calculated using two years of Medicare FFS claims data.

Level of Analysis: Facility; Other: Stay

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Sandi Hyde, LifePoint Health
- Holly Wolff, Subject Matter Expert

MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

Description: This measure estimates the risk-adjusted rate of healthcare-associated infections (HAIs) that are acquired during skilled nursing facility (SNF) care and result in hospitalizations. The measure is risk adjusted to "level the playing field" and to allow comparison of performance based on residents with similar characteristics between SNFs. The one-year measure is calculated using the following formula: (risk-adjusted numerator/risk-adjusted denominator)*national observed rate. It is important to recognize that HAIs in SNFs are not considered "never-events." The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs when compared to their peers.

Level of Analysis: Facility; Other: Stay

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Holly Wolff, Subject Matter Expert
- Rhonda Robinson Beale, UnitedHealth Group

MUC2021-137: Total Nursing Hours Per Resident Day

Description: Total nursing hours (RN + LPN + nurse aide hours) per resident day. The source for total nursing hours is CMS's Payroll-based Journal (PBJ) system. The denominator for the measure is a count of daily resident census derived from Minimum Data Set (MDS) resident assessments. The measure is case-mix adjusted based on the distribution of MDS assessments by Resource Utilization Groups, version IV (RUG-IV groups).

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Ana Verzone, Subject Matter Expert
- Rhonda Robinson Beale, UnitedHealth Group

Measures Proposed for Multiple Programs

MUC2021-136: Screening for Social Drivers of Health

Description: Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.

Level of Analysis: Clinician; Group; Facility; Other: Beneficiary, Population

Risk Adjustment: Stratified

Lead Discussants:

- Brock Slabach, National Rural Health Association
- Cody Mullen, Subject Matter Expert

MUC2021-136: Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
  - Pay-for-performance
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
  - The MIPS performance categories and finalized 2021 weights:
    - Quality (40%)
    - Promoting Interoperability (25%)
    - Improvement Activities (15%)
    - Cost (20%)
    - The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
  - Improve quality of patient care and outcomes for Medicare FFS.
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.

MUC2021-136: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-134: Screen Positive Rate for Social Drivers of Health

Description: Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.

Level of Analysis: Clinician; Group; Facility; Other: Beneficiary, Population

Risk Adjustment: Stratified

Lead Discussants:

- Crystal Barter, Michigan Center for Rural Health
- National Rural Letter Carriers' Association (NRLCA)

MUC2021-134: Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
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MUC2021-134: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-084: Hospital Harm – Opioid-Related Adverse Events

Description: This measure assesses the proportion of inpatient hospital encounters where patients ages 18 years of age or older have been administered an opioid medication, subsequently suffer the harm of an opioid-related adverse event and are administered an opioid antagonist (naloxone) within 12 hours. This measure excludes opioid antagonist (naloxone) administration occurring in the operating room setting.

Level of Analysis: Facility

Risk Adjustment: None

Lead Discussants:

- Stephen Tahta, American Hospital Association
- Rev. Bruce Hanson, Subject Matter Expert

MUC2021-084: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-084: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

Break

MUC2021-118: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Description: The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to 90 days post-date of the index admission (the admission included in the measure cohort).

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Sandi Hyde, LifePoint Health
- Michael Fadden, Subject Matter Expert

MUC2021-118: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-118: Hospital Value-Based Purchasing Program (VBP)

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2% of base operating diagnosis-related group (DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments.
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards.

MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital

Description: The measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital and assesses the cost to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during an MSPB Hospital episode, which is comprised of the periods 3-days prior to, during, and 30-days following a patient's hospital stay. The measure is not condition specific and uses standardized prices when measuring costs. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who were discharged between January 1 and December 1 in a calendar year from short-term acute hospitals paid under the Inpatient Prospective Payment System.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted; Stratified

Lead Discussants:

- Perry Payne, Truven Health Analytics LLC/IBM Watson Health
- Collette Cole, Minnesota Community Measurement

MUC2021-131: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

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- **Incentive Structure:** The amount equal to 2% of base operating diagnosis-related group (DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments.
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards.

MUC2021-104: Severe Obstetric Complications eCQM

Description: Proportion of patients with severe obstetric complications which occur during the inpatient delivery hospitalization.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted; Stratified

Lead Discussants:

- Anisha Turner, American College of Emergency Physicians
- Ana Verzone, Subject Matter Expert

MUC2021-104: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-104: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure

Description: This measure tracks the development of new *Clostridioides difficile* (*C. difficile*) infection among patients already admitted to healthcare facilities, using algorithmic determinations from data sources widely available in electronic health records. This measure improves on the original measure by requiring both microbiologic evidence of *C. difficile* in stool and evidence of antimicrobial treatment.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Collette Cole, Minnesota Community Measurement
- Brock Slabach, National Rural Health Association

MUC2021-098: Proposed Programs

- **Hospital Programs**
  - Hospital-Acquired Condition Reduction Program
  - Hospital Inpatient Quality Reporting Program
  - Medicare Promoting Interoperability Program for Hospitals
  - Prospective Payment System (PPS)-Exempt Cancer Hospitals Quality Reporting Program
- **PAC/LTC Programs**
  - Inpatient Rehabilitation Facility Quality Reporting Program
  - Long-Term Care Hospital Quality Reporting Program
  - Skilled Nursing Facility Quality Reporting Program

MUC2021-098: Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce hospital-acquired conditions (HACs) through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

MUC2021-098: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-098: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-098: PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- **Program Type:** Quality Reporting Program
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

MUC2021-098: Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** IRFs that fail to submit data will have their applicable IRF Prospective Payment System (PPS) payment update reduced by 2%.
- **Program Goal:** Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

MUC2021-098: Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

- **Program Type**: Pay for reporting and public reporting
- **Incentive Structure**: Long-term care hospitals (LTCHs) that fail to submit data will have their applicable annual payment update (APU) reduced by 2%.
- **Program Goal:** Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).

MUC2021-098: Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Skilled nursing facilities (SNFs) that do not submit the required quality data will have their annual payment update reduced by 2%.
- **Program Goals:** Increase transparency so that patients are able to make informed choices.

MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

Description: This measure tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records. This measure includes many healthcare-associated infections not currently under surveillance by the Center for Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Perry Payne, Truven Health Analytics LLC/IBM Watson Health
- Stephen Tahta, American Hospital Association

MUC2021-100: Proposed Programs

- **Hospital Programs**
  - Hospital-Acquired Condition Reduction Program
  - Hospital Inpatient Quality Reporting Program
  - Medicare Promoting Interoperability Program for Hospitals
  - Prospective Payment System (PPS)-Exempt Cancer Hospitals Quality Reporting Program

MUC2021-100: Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce hospital-acquired conditions (HACs) through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

MUC2021-100: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-100: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
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Discussion of Rural Health Hospital Program


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Rural Emergency Hospitals

Presented by

Grace Snyder

Director, Division of Value-Based Incentives and Quality Reporting

Center for Clinical Standards & Quality

Vinitha Meyyur

Deputy Director, Division of Quality Measurement

Center for Clinical Standards & Quality

Background

Consolidated Appropriations Act, 2021 (CAA) (Section 125, pg. 1779) establishes a new provider type – Rural Emergency Hospitals (REHs)

Rural Emergency Hospitals

- Must convert from either a rural hospital with less than 50 beds or a Critical Access Hospital
- Must provide emergency services and observation care
- May provide other outpatient services as specified by the Secretary through rulemaking

Rural Emergency Hospitals

- Permitted to provide Skilled Nursing Facility (SNF) services in a distinct part licensed as a SNF
- Eligible for payment for items and services furnished on or after January 1, 2023
- REHs will receive a 5 percent payment increase for rural emergency hospital services

Health and Safety Standards/CoPs

The CAA requires the following:

- REHs must be staffed 24/7
- A physician, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish REH services 24 hours a day
- REHs must meet the applicable CAH staffing and staffing responsibilities requirements under 42 CFR 485.631

Health and Safety Standards/CoPs (cont'd.)

The CAA requires the following:

- REHs must have a transfer agreement with a level I or level II trauma center
- REHs must meet the CAH emergency services requirements at 42 CFR 485.618 and the applicable hospital emergency department requirements
- REHs are subject to the EMTALA requirements under section 1867 of the Social Security Act

Request for Information (RFI)

- Published in the CY 2022 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System Proposed Rule on August 4, 2021 (CMS-1753-P, 86 FR 42018)
- Target areas in the RFI included: Health and safety standards; Payment policies; Quality measures and quality reporting; Health equity; Additional considerations and unintended consequences that should be taken into account

Quality Measures and Quality Reporting

Promote higher quality, more efficient health care for Medicare beneficiaries through measurement.

The CAA requires the following, beginning with 2023 (on or after 1/1/2023):

- REHs shall submit data on quality measures
- Measures selected for the REH Quality Reporting Program are at the Secretary's discretion
- Quality measure data shall be made publicly available on a CMS website
- The REH provision does NOT specifically include statutory language linking reporting to a payment structure.

Quality Measures and Quality Reporting

In Q4 of 2021 and CY2022, we plan to solidify the measurement portfolio for REH Quality Reporting:

- Pre-Rulemaking - Measures Under Consideration (MUC) List and Measures Application Partnership (MAP) in 2022
- Receive Input from Stakeholders on measures to consider for inclusion in the Reporting Program
- **Discussion items:**
  - **Measure Concepts relevant to the setting**
  - **Type of Measures (Process, Outcome)**
  - **Data submission methods**

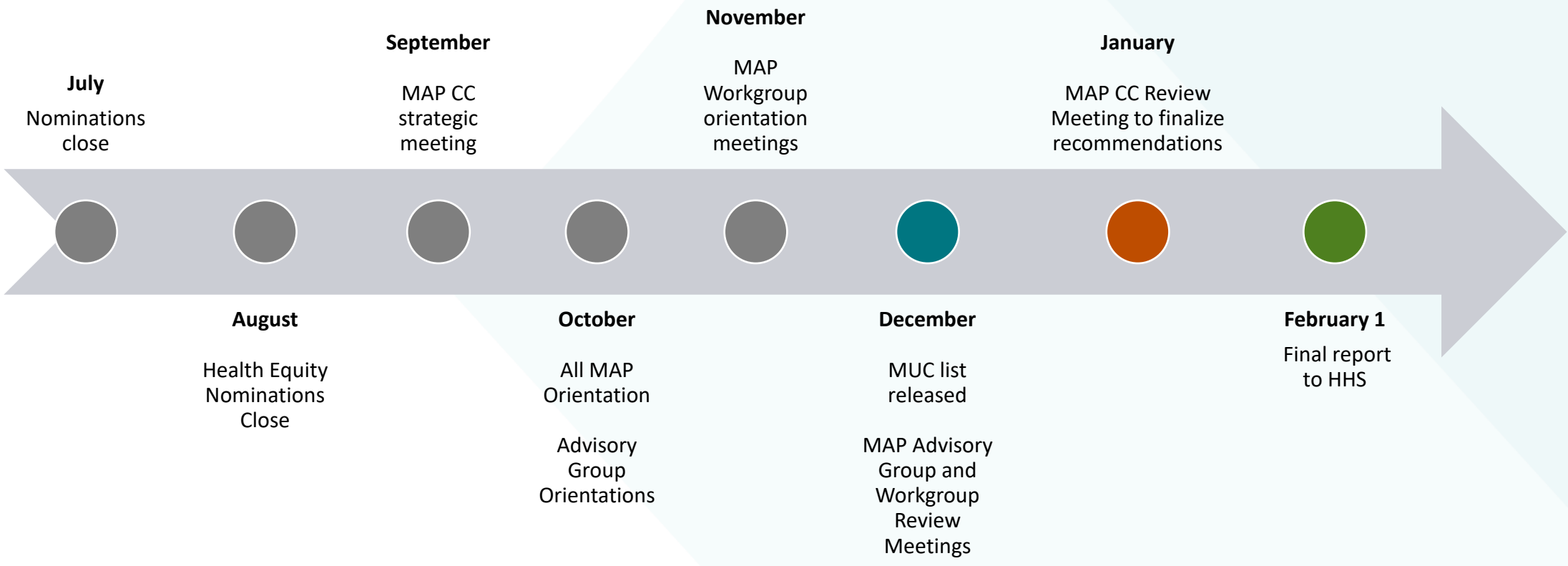
Public and Member Comment

Next Steps

Timeline of Upcoming Activities

- **Public Comment Period 1** – December 3, 2021 – December 9, 2021
- **Workgroup Review Meetings**
  - Clinician Workgroup – **December 14**
  - Hospital Workgroup – **December 15**
  - Post-Acute/Long-Term Care (PAC/LTC) Workgroup – **December 16**
  - Coordinating Committee – **January 19, 2022**
- **Public Comment Period 2** – December 30, 2021 – January 13, 2022
- **Final recommendations to CMS** – by February 1st, 2022

Timeline of Upcoming Activities (cont.)



Contact Information

- Project page:
  - https://www.qualityforum.org/MAP_Rural_Health_Advisory_Group.aspx
- Advisory Group SharePoint site:
  - https://nationalqualityforumdc.sharepoint.com/sites/MAPRuralHealth
- Email:
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THANK YOU.

NATIONAL QUALITY FORUM

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